Check List

Please fill out the following forms, policies and email them to dsg@dsglisw.com

Intake Information Form: Please fill in, sign, date and return via email to dsg@dsglisw.com

Insurance Information Form: Please add the needed information and send with copies of the front and back of your insurance card and return via email to dsg@dsglisw.com

Policies: Please read, sign and date and return via email to dsg@dsglisw.com

Privacy Policies: Please review then sign, date the last page and return via email return to dsg@dsglisw.com

Any additional questions please contact me at 440-442-8600 or via email to dsg@dsglisw.com

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Insurance Information

Your Name:

Insurance Company:

Is Policy In Effect?:

Do You Need Pre-Authorization?:

Claims Filing Address (For This Policy's Mental Health Services):

Paylor ID# (If Available):

Has Your Deductible Been Met?: Yes No

What Is Your Co-Pay?:

Yearly Max Number Of Visits:

If Your Policy Has Rolling Year List Dates:

Additional Information:

Please make sure to email copies of this form and insurance cards (front and back) to dsg@dsglisw.com

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Client Intake Information Form

Client Information

First: MI: Last: Date Of Birth:

Address: City: State: Zip:

Home Phone: Cell: Work: Email:

Social Security #: Employed: Self-Employed: Student: Full-Time: Part-Time:

Martial Status: Married: Single: Widowed: Divorced: Separated: Male: Female: Other:

Responsible Party Information (If Other Than Client - If there are two responsible parties please fill out a second form)

First: MI: Last:

Address: City: State: Zip:

Home Phone: Cell: Work: Email:

Relationship:: Male: Female: Other:

Insurance Company Information (Please attached a copy of your insurance card front and back)

Insurance Company: ID#: Policy#:

Address: City: State: Zip:

Company Phone: Work: Email: Web Address:

Policy Holder Information If Same As Above:

First: MI: Last:

Address: City: State: Zip:

Home Phone: Cell: Work: Email:

Employer: Date Of Birth: Social Security#: Male: Female: Other:

Are you under Employer's Health Plan? Yes: No:

What is your relationship to the insured? Spouse: Child: Self: Other:

Status (For Champus Claims)? Active: Retired: Deceased: Other:

I authorize Deborah Squires Goeble, LISW-S, to release the information necessary to my insurance company for the purpose of billing for services rendered. I also understand that the remaining balance after insurance payment is my responsibility (including copays, deductible, and non-covered services). I authorize payments of my medical benefits to Deborah Squires Goeble, LISW-S.

Signature: Date:

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Policies

I am pleased that you have chosen my services and I hope you find the following information helpful.

Telephone Calls: You may leave a message anytime. Your call will be returned as soon as possible. If you are unable to reach me and you are experiencing an emergency please call 911 or go to the emergency department of your nearest hospital. Telephone or audio visual consultation can be provided at the same rate as an office visit.

Cancellations: Please schedule appointments you are reasonably certain you can keep. If you must cancel an appointment, please do so at least 48 hours in advance. If you handle a cancellation in this manner it is possible to offer your scheduled time to another person. Cancellations made without this notice may be charged to you.

Insurance: As a courtesy, this office will submit insurance claims to your carrier on your behalf. However, your insurance contract is between you and your insurance company. Ultimately, you are responsible for payment for services. In accepting this courtesy, you agree not to hold this office liable for insurance processing problems.

Fees: The current fee is $150 per clinical hour (45-50 minutes). Unless otherwise specified, any session longer than that will be charged at the hourly rate.

Payments: It is simplest if payment (co-payment) are made at the time of service. Your billing statements will reflect services given, payments received and UCR discount adjustments applied. Balances which remain unpaid for an unreasonable length of time may be subject to a 1.5% per month interest charge. If you are unable to pay the balance do not hesitate to call and a payment plan can easily be arranged. Options for on-line payments are available under payment options tab on website www.deborahsquiresgoeble.com

Information Update: Please notify me of any changes in your address, telephone number or insurance information. Please email copies of your insurance coverage cards (front and back) to dsg@dsglisw.com

Thank you for the confidence you show by choosing to work with me at this time. It is my privilege to work with you.

I have read, understand and agree to the above.

Signature _____ Date _____

I have received and reviewed a copy of the Notice of Privacy Practices from this office.

Signature _____ Date _____

Rev 6.2021

DEBORAH SQUIRES GOEBLE

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but I will obtain consent in another form for disclosing outside of my practice, except as otherwise outlined in this Policy. In all instances I will only disclose the minimum necessary information in order to accomplish the intended purpose. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information, including uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children, except in some limited instances where they are involved in your health care, in which case I will obtain your consent first. Any disclosure involving psychotherapy notes will require your signed authorization , unless I am otherwise allowed or required by law to release them.

III. Uses and Disclosures Requiring Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization as allowed by law, including under the following circumstances:

- Serious Threat to Health or Safety: If I believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). I will inform you about these notices and obtain your written consent, if I deem it appropriate under the circumstances.
- Worker's Compensation: If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.
- Felony Reporting: I may be required or allowed to report any felony that you report to me that has been or is being committed.
- For Health Oversight Activities: I may use and disclose PHI if a government agency is requesting the information for health oversight activities. Some examples could be audits, investigations, or licenser and disciplinary activities conducted by agencies required by law to take specified actions to monitor health care providers, or reporting information to control disease, injury or disability.
- For Specific Governmental Functions: I may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, and for national security reasons, such as for protection of the President.
- For Lawsuits and Other Legal Proceedings: If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

continued next page

III. Uses and Disclosures Requiring Neither Consent nor Authorization continued

- Abuse, Neglect, and Domestic Violence: If I know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child or developmentally disabled individual under 21, the law requires that I file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, I may be required to provide additional information. If I have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that I report such belief to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information. If I know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, I must note that knowledge or belief and the basis for it in the patient's or client records.
- To Coroners and Medical Examiners: I may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.
- For Law Enforcement: I may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- Required by Law. I will disclose health information about you when required to do so by federal, state or local law.
- Public Health Risks. I may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.
- Information Not Personally Identifiable. I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- Other uses and disclosures will require your signed authorization.

IV. Patient's Rights and Duties

Patient's Rights:

- Right to Request Restrictions and Disclosures–You have the right to request restrictions on certain uses and disclosures of protected health information about you for treatment, payment or health care operations. However, I am not required to agree to a restriction you request, except under certain limited circumstances, and will notify you if that is the case. One right that I may not deny is your right to request that no information be sent to your health care plan if you pay in full for the health care plan service ahead of time. If you select this option then you must request it and must pay in full each time a service is going to be provided. I will then not send any information to the health care plan for that session unless I am required by law to release this information.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. If your request is reasonable, then I will honor it.
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except under some limited circumstances. This does not apply to information created for use in a civil, criminal or administrative action or proceeding. I may charge you reasonable amounts for copies, mailing or associated supplies. I may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to your PHI, you may ask that my denial be reviewed.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request, but will note that you made the request. Upon your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI, not including disclosures for treatment, payment or health care operations, for paper records on file for the past six years and for an accounting of disclosures made involving electronic records, including disclosures for treatment, payment or health care operations, for a period of three years. On your request I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- I am required by law to maintain the privacy of PHI, to provide you with this notice of my legal duties and privacy practices with respect to PHI, and to abide by the terms of this notice.
- I reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI I maintain.
- If I revise my policies and procedures, which I reserve the right to do, I will make available a copy of the revised notice to you on my website, if I maintain one, and one will always be available at my office. You can always request that a paper copy be sent to you by mail.
- In the event that I learn that there has been an impermissible use or disclosure of your unsecured PHI, unless there is a low risk that your unsecured PHI has been compromised, I will notify you of this breach.

continued next page

V. Complaints
If you are concerned that I have violated your privacy rights, or you disagree with a decision I make about access to your records, you may file a complaint with me and I will consider how best to resolve your complaint. Contact me, the Privacy Officer, if you wish to file a complaint with me. In the event that you aren't satisfied with my response to your complaint, or don't want to first file a complaint with me, then you may send a written complaint to the: **Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or to: Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.**
Phone (312) 886-2359, Fax (312) 886-1807, TDD (312) 353-5693.
There will be no retaliation against you for filing a complaint.

VI. Effective Date:
This notice is effective as of September 23, 2013.

VII. Privacy and Security Officer
I act as my own Privacy and Security Officer. My contact information is listed at the beginning of this form.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By signing this document, I acknowledge that I have received a copy of the Notice of Privacy Practices form.

_____

Print Name Signature Date

_____

(Therapist must verify the identity and authority of a personal representative)

Or list attempts that were made to obtain a signature and distribute the form to the client

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